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ABSTRACT

This paper, addressed to school board members and financial officers, suggests seven ways to obtain the most out of every budget dollar allocated for employee fringe benefits, including hospital, surgical, medical, dental, disability, and death. The suggestions are to consider (1) self-funding of benefits, (2) eliminating the payment of insurance commissions, (3) reviewing the administration of the benefit program, (4) receiving a complete actuarial and consulting report each year, (5) stepping up employee communications that describe the benefits available, (6) receiving a report on new developments relating to cost containment, and (7) purchasing insurance jointly with other districts. (Author/LD)

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

"HAVE YOU THOUGHT ABOUT...."

BENEFIT PROGRAMS: PIT OR PENDULUM?

Proposition 13 and taxpayer revolts have been big news makers lately. The surfacing of general taxpayer discontent, however, cannot be news to School Boards which, for many years and in increasing number of Districts, have encountered taxpayer budget rejections. Such rejections often stem from a conviction that School Districts are not taking all the steps available to keep costs under control.

One cost area often overlooked by even the most budget-conscious School District is that of "fringe benefits" for the professional, clerical and support staff. Such benefits, which represent a substantial and growing percentage of the School District budget, include hospital, surgical, medical, dental, disability, death and related coverages. Their costs have been increasing at a faster rate than most items in the Consumer Price Index and, in some Districts, account for as much as 10% of payroll - in addition to retirement costs which may exceed 20% of payroll.

It is appropriate during any school year to consider whether in the last year or two the District's chief financial officer has addressed important issues concerning the benefits provided the School District employees. A useful starting point - suggested by our actuarial and consulting experience - is to consider the following check-list. It can serve two purposes:

(1) As a stimulus to think about the many vital issues affecting employee benefits, and

(2) as a basis for future action.

CHECKLIST ITEM #1

HAS YOUR DISTRICT RECEIVED A RECENT REPORT ON THE MERITS OF SELF-FUNDING?

The opportunity to self-fund health care and related benefits is not only for industrial giants. You will note that I am using the term "self-fund" rather than the term "self-insurance" which term is in fact a misnomer. To eliminate confusion with terms, we can assume that the common element of insured programs is risk allocation. When the size of a particular group increases, the expected number of claims goes up and the expected payment for a single claim in relationship to the total payment goes down. Insurance cooperatives were formed so that the risk of loss for any one individual could be covered by exposing enough individuals to a similar risk of loss. If a decision is made to terminate the traditional group insurance policy and instead self-fund benefits, you elect to assume benefit payments (and the risk) yourself instead of sharing the risk of loss with other groups. Consequently, the term "self-funding" more accurately describes this method, since self-insurance implies sharing the risk of loss. To the extent that the right circumstances exist, and that savings can be demonstrated by lower insurance expenses and legal avoidance of State premium taxes, any School District can self-fund some benefits. Risks can be limited through the medium of a stop-loss insurance contract or through re-insurance. The issues admittedly are complex and

require detailed technical analysis, for the non-experience-rated premium costs for stop-loss coverage could eliminate savings achieved under self-insurance. However, it bears mention that programs should not continue to purchase conventional insurance only because that has been the traditional route. Available alternatives should be explored on the basis of their soundness and potential economy.

Such alternatives that should be considered are available through Blue Cross-Blue Shield as well as commercial insurers. Generally speaking, these alternative contracts can be referred to as Administrative Services Only or A S O contracts. They provide the services of the organization without asking the organization to accept the risk while still providing contractual discounts (as through the Blues) or claim payment facilities. Here again, if properly designed, such contracts can legally avoid State premium taxes.

The effect of utilizing such a contract or, for that matter, self-funding is to release additional dollars to reduce the cost of the program to the School District and/or employee or to increase the benefits without additional cost.

CHECKLIST ITEM #2

HAS YOUR DISTRICT CONSIDERED ELIMINATING THE PAYMENT OF INSURANCE COMMISSIONS?

Insurance commissions are commonly paid on the group insurance bought by School Districts. Such commissions can be

paid on various bases, some high and some low. However, in most States an insurance company can be directed, at the option of the policyholder, not to pay commissions to anyone for group insurance policies and not to charge any commissions to the account.

It is a fact that group insurance contracts beyond a certain size are experience-rated and operate on a retention-accounting basis. Aside from maximum rate protection, this means that such a contract is essentially on a cost-plus basis. Here is a simplified example of an experience accounting:

Earned Premium		$3,000,000
Incurred Claims	$2,500,000	
Insurance Company Retention	200,000	2,700,000
Dividend		$ 300,000

The retention item might be broken down as follows:

State Premium Taxes	$ 60,000
Commissions	30,000
All Other (claims expenses, booklet expense, policy expenses, contingency reserves, surplus, profit)	110,000

From this you can see that, aside from incurred claims, which would be the same regardless of carrier or if self-funded, the net cost of the insurance was $200,000. In that $200,000 was a charge for $30,000 of commissions paid to an insurance agent or broker. If those commissions were eliminated, the retention would have been reduced to $170,000 and the dividend would have been increased from $300,000 to $330,000.

The elimination of commission payments could lead to a direct reduction in insurance costs. With the savings achieved, the School District could retain benefit advisors whose fee may be less than the commissions formerly paid on the insurance contracts. Of course, commissions can be used to pay for services of an advisor. In such cases, the School District should make certain it actually obtains the services of a consultant qualified to advise on benefit programs.

CHECKLIST ITEM #3

HAS YOUR DISTRICT RECENTLY CONSIDERED WHETHER BENEFIT PROGRAM ADMINISTRATION IS EFFICIENT AND ECONOMIC?

The best of programs will fail if administration is inefficient, if claim payments are delayed or are mistakenly processed. Are too many people in the administration office involved in this area - or perhaps not enough? Are the insurance company's facilities used to full advantage? This latter question is of particular significance since most programs are insured and the insurance companies pay claims.

Some thought should be given to an independent study and review of the administration of the benefit program. This can be accomplished by the Personnel Department or with the help of outside consultants.

CHECKLIST ITEM #4

DOES YOUR DISTRICT RECEIVE A COMPLETE ACTUARIAL AND CONSULTING REPORT EACH YEAR WHICH, AMONG OTHER THINGS, PROVIDES BUDGETARY PLANNING INFORMATION?

Is there available for annual review a professionally drawn

report which analyzes insurance company expenses (or direct benefit expenses if the program is self-funded) and discusses reserves, retentions and rate renewal proposals? Has the District received advice as to whether the benefit program should be submitted to competitive bidding - or been assumed that the current program remains competitive? Does it from time to time review the District's benefit plan design to determine that it remains rational and sound while meeting the needs of the employees? Does the consulting report suggest how your benefit plans integrate with other sources of benefit payments?

Most importantly, does the actuarial and consulting report present for consideration a projected budget of expenses predicated upon present claims experience? Does it present for consideration a proposed budget of expenses for several years into the future based upon current claims experience, trend factors and known inflationary factors in health care delivery systems? Does the report present suggestions about how this budget is to be dealt with in the current year and even in the next several years after that, as for example the establishment of a reserve or insurance account to minimize budget fluctuations?

CHECKLIST ITEM #5

HAS YOUR DISTRICT GIVEN ADEQUATE CONSIDERATION TO EMPLOYEE COMMUNICATIONS?

Has sufficient attention been directed towards the descriptive literature prepared for School District employees explaining their benefits? Has the District considered preparing

and distributing an annual report to employees which, among other things, details the benefit expenditures of the District and which personalizes the importance of the benefits through reference to specific (but, of course, unnamed) cases of particularly large reimbursements? Does the District's literature demonstrate to employees the mutual interest they share with the District in not abusing benefits? Does it encourage pre-delivery discussions with doctors, dentists and other providers of health care about the nature, extent and costs of their services?

This last point should be stressed. Doctors should be queried as to the extent and cost of the services they are going to perform. Financier J. P. Morgan once commented to someone interested in buying his yacht that "If you must ask how much it costs to maintain a yacht, you can't afford it." This certainly does not apply to the area of providing medical services.

CHECKLIST ITEM #6

HAS YOUR DISTRICT RECEIVED A REPORT ON NEW DEVELOPMENTS RELATING TO COST CONTAINMENT?

Cost containment is of prime importance to any health benefit package, for as previously noted, health care cost increases have far outstripped changes in the overall cost of living. Health care accounted for only 4-1/2% of the gross national product in 1950 and almost 8-1/2% in 1977. During the years 1973 to 1977, the average increase in the overall cost of living (Consumer Price Index) rose at an average rate of 7.7% per year. Medical care outpaced the CPI increase - its average increase was 8.9% per

year compared with the 7.7% CPI increase. The components of the medical care index vary greatly. Hospital costs inflated the most - at an average of 10.5% annually. Prescriptions, on the other hand, increased only at an average of 3.9% annually during this 5-year period.

A sharpened focus on cost-saving actions is not hard to understand. Health care costs now account for approximately 8.8% of the Gross National Product. This means that the average worker now devotes the equivalent of 4-1/2 weeks of work per year to paying health care costs. In 1965, 3 weeks of work was enough to pay the health care bill; in 1955, 2 weeks.

This upward trend shows no sign of abating and, of course, will affect your District's costs either directly or indirectly. While it is appropriate to note that we are dealing here with economic, scientific, social and cultural forces which are subject only to limited control even by the Federal Government, and that no one employer can hope to reverse national trends, moderating the increase of costs in specific cases is clearly possible and worth the effort.

Among important areas to consider are the use of Health Maintenance Organizations, the institution of mandatory second surgical opinion programs, pre-treatment reviews for dental services, a system of monitoring hospital admissions for medical necessity and appropriate length of stay, and control programs

to cope with hypertension, obesity, alcoholism and smoking. All of these are relevant for consideration by any School District, regardless of size.

Health Maintenance Organizations, commonly referred to as HMOs, are capable of cutting health care costs on the order of 10% to 20%. The HMO is a formally organized system for providing comprehensive, prepaid health care to a voluntarily enrolled group. It emphasizes prevention on the theory that early attention to medical problems is both good medicine and good economics. HMOs have a good record for keeping hospital stays short and holding costs to a minimum. Their popularity is increasing steadily.

The relatively high frequency of unnecessary surgery has been documented. The avoidance of one unnecessary in-hospital surgical procedure can lead to an average savings of over $3,000; hence, the growing popularity of second surgical opinion programs, in which a recommendation for surgery is discussed with a second physician to determine whether such surgery is justified in his opinion.

Second surgical opinion programs can be designed several different ways - to be utilized either on a mandatory basis or a voluntary basis. If the program is mandatory then the employee must have a second surgical opinion before surgery is performed on an other-than-emergency basis. If the second opinion is not obtained, then no benefits are payable by the program. If the

program is established on a voluntary basis, then the employee is not required but rather encouraged to seek a second surgical opinion. Regardless of whether or not the second opinion is solicited, the program would pay the benefits. However, a program could still be voluntary that would require the employee to seek a second opinion but then, after the opinion was obtained, this second opinion would not have a bearing on whether or not the surgery expenses would be reimbursed by the program.

If your community has established a Professional Standards Review Organization, or P S R O, you have a vehicle in place whereby employees receive approval before hospital admittance in non-emergency cases. P S R O is specifically directed to do three key things:

1) to determine whether covered services are or were medically necessary;
2) to determine whether the quality of such services meets professionally recognized standards of health care; and
3) to determine, on all proposed bed cases, whether such services or items could be effectively provided on an out-patient basis or more economically in an in-patient health facility of a different type.

I urge you to determine if a P S R O is available in your community. Even if a P S R O is not available, you may find a Medical Foundation such as in Phoenix, Arizona, and Sacramento, California that provides

essentially this same service through a private cooperative of physicians.

Money spent to create free programs to control hypertension, obesity, alcoholism and smoking can return itself many times over in savings on hospitalization and medical care avoided, unused sick leave days and the prevention of dislocations that might otherwise result from these conditions if untreated.

CHECKLIST ITEM #7

HAS YOUR DISTRICT CONSIDERED THE JOINT PURCHASE OF INSURANCE?

Insurance administration costs, like those of many other products, are decremental. The larger the case, the less the administration cost is as a percentage of the premium. The larger the case, the more weight exercised by the policyholder vis-a-vis the insurer. The larger the case, the fewer restrictions placed upon the benefits or the underwriting conditions. A number of small or moderate sized School Districts could consider the joint purchase of group insurance for benefits which they provide in common or, of course, they could join for self-funding their programs utilizing a common administrator.

The foregoing questions don't begin to exhaust the matters that should be addressed by School Boards and financial officers over time and which regularly come up in the course of professional actuarial and consulting practice. But if your District considers these questions and boldly carries each of them through to resolution, it will be well on the way to obtaining the most out of each budget dollar allocated for fringe benefits - an accomplishment certain to generate widespread taxpayer approval.